



Authorization for Disclosure of Protected Health Information

Patient's Name: _____ **Social Security Number:** _____
Address: _____ **Telephone Number:** _____
Date of Birth: _____ **Insured Status:** **Insured** **Not Insured**

I authorize the disclosure of my health information as described in this authorization.

Health Care Practitioner Disclosing the Information:	Organization Receiving the Information:
Name: _____	New Hampshire Healthy Kids Corporation
Address: _____	1 Pillsbury Street, Suite 300
Telephone: _____	Concord, NH 03301
Fax: _____	Phone (603) 228-2925 Fax (603) 228-8940

The information to be used or disclosed: I specifically authorize the disclosure of my name, social security number, address, telephone number, date of birth and insured status.

The purpose of the request: To enable the New Hampshire Healthy Kids Corporation, on a confidential basis, to contact me regarding possible health insurance coverage under one of its programs.

I understand that I have the right to revoke (cancel) this authorization at any time. I understand that to revoke this authorization, I must do so in writing and send my written revocation (cancellation) to the office of the health care practitioner listed above. I understand that the revocation will not be effective until it is received, and it will not apply to information that has already been released pursuant to this authorization.

Unless earlier revoked in writing, this authorization will expire on ____, __, 20__, or the date that is **one-year** from the date I executed this authorization, whichever is later.

I understand that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits from the health care practitioner listed above.

I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by the federal rule on the privacy of medical records.

I understand and consent to a representative of New Hampshire Healthy Kids Corporation contacting me (or my legal representative) by telephone with information regarding the New Hampshire Healthy Kids program.

I have had an opportunity to review and fully understand the content of this authorization. I understand that signing this authorization is voluntary. By signing this authorization form, I am confirming that it accurately reflects my wishes, and I hereby authorize release of my information as described above.

Signature of Patient, Parent or Legal Representative Date

Printed Name of Patient, Parent or Legal Representative Language Spoken by Patient, Parent or Legal Representative (if not English)

Legal Representative Relationship to Patient:
 Legal Guardian Court Appointed Guardian Other _____

Please fax completed form to: (603) 228-8940 or mail to: 1 Pillsbury St., Suite 300, Concord, NH 03301